

24. MEDICARE

Table 24-1. FEDERAL RESOURCES IN SUPPORT OF MEDICARE

(In millions of dollars)

Function 570	1998 Actual	Estimate					
		1999	2000	2001	2002	2003	2004
Spending:							
Discretionary Budget Authority	2,723	2,989	2,926	2,926	2,926	2,926	2,926
Mandatory Outlays:							
Existing law	190,233	202,037	214,944	229,182	233,195	251,244	265,201
Proposed legislation			-1,243	-1,496	-1,526	-1,673	-1,824

Created by the Social Security Amendments of 1965, and expanded in 1972, Medicare is a Nation-wide health insurance program for the elderly and certain people with disabilities. The program, which will spend an estimated \$217 billion in 2000 on benefits and administrative costs, consists of two complementary but distinct parts, each tied to a trust fund: (1) Hospital Insurance (Part A) and; (2) Supplementary Medical Insurance (Part B).

Over 30 years ago, Medicare was designed to address a serious, national problem in health care—the elderly often could not afford to buy health insurance, which was more expensive for them than for other Americans because they had higher health care costs. Medicare was expanded in 1972 to address a similar problem of access to insurance for people with disabilities. Through Medicare, the Federal Government created one insurance pool for all of the elderly and eligible disabled individuals while subsidizing some of the costs, thus making insurance much more affordable for almost all elderly Americans and for certain people with disabilities.

Medicare has very successfully expanded access to quality care for the elderly and people with disabilities, but at an increasing cost. The Balanced Budget Act (BBA) of 1997 improved Medicare's financial outlook for the near future, yet its trust funds face financing challenges as the Nation moves

into the 21st Century. Along with legislative proposals discussed elsewhere in the budget, the Health Care Financing Administration (HCFA), which runs Medicare, is working to improve Medicare through its regulatory authority and demonstration programs.

Because it serves almost 40 million Medicare beneficiaries, HCFA has been designated as a High Impact Agency by the National Partnership for Reinventing Government. To meet the challenges of the changing health care system and increase responsiveness to its constituencies, HCFA has begun a process of management reform (see Section IV). Included in this reform are increased management and program flexibilities, increased accountability to constituencies, structural reforms, and legislative changes to promote competition and increase efficiency in Medicare contracting.

The Department of Health and Human Services (HHS), which houses HCFA, is the Federal Government's lead agency for health programs. HHS' Strategic Plan states the agency mission as: "to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services." Medicare supports HHS' second, third, fourth and sixth strategic goals, as described in Chapter 23, "Health."

Part A

Part A covers almost all Americans age 65 or older, and most persons who are disabled for 24 months or more and who are entitled to Social Security or Railroad Retirement benefits. People with end-stage renal disease (ESRD) also are eligible for Part A coverage. Part A reimburses providers for the inpatient hospital, skilled nursing facility, home health care related to a hospital stay, and hospice services provided to beneficiaries. Part A's Hospital Insurance (HI) Trust Fund receives most of its income from the HI payroll tax—2.9 percent of payroll, split evenly between employers and employees.

Part B

Part B coverage is optional, and it is available to almost all resident citizens age 65 or older and to people with disabilities who are entitled to Part A. About 94 percent of those enrolled in Part A have chosen to enroll in Part B. Enrollees pay monthly premiums that cover about 25 percent of Part B costs, while general taxpayer dollars subsidize the remaining costs. For most beneficiaries, the Government simply deducts the Part B premium from their monthly Social Security checks.

Part B pays for medically necessary physician services; outpatient hospital services; diagnostic clinical laboratory tests; certain durable medical equipment (e.g., wheelchairs) and medical supplies (e.g., oxygen); home health care; physical and occupational therapy; speech pathology services; and outpatient mental health services. Part B also covers kidney dialysis and other services for ESRD patients.

Fee-for-Service vs. Managed Care

Beneficiaries can choose the coverage they prefer. Under the traditional fee-for-service option, beneficiaries can go to virtually any provider in the country. Medicare pays providers primarily based on prospective payment, an established fee schedule, or reasonable costs. About 85 percent of Medicare beneficiaries now opt for fee-for-service coverage.

Alternatively, beneficiaries can enroll in a Medicare managed care plan, and the 15 percent who do are concentrated in several geographic areas. Generally, enrollees receive

care from a network of providers, although Medicare managed care plans may offer a point-of-service benefit, allowing beneficiaries to receive certain services from non-network providers. Additional kinds of managed care plans, including provider sponsored organizations and preferred provider organizations, will be phased in for Medicare beneficiaries over the next few years as part of Medicare + Choice.

Most managed care plans receive a monthly, per-enrollee capitated payment that covers the cost of Part A and B services. As of March 1998, 72 percent of all Medicare beneficiaries lived in a county served by at least one Medicare managed care plan.

Successes

Medicare has dramatically increased access to health care for the elderly—from slightly over 50 percent of the elderly in 1966 to almost 100 percent today. According to a recent Medicare Payment Advisory Commission report, 97 percent of Medicare fee-for-service beneficiaries (94 percent for managed care) reported no trouble obtaining care. Further, 88 percent of fee-for-service Medicare beneficiaries (92 percent for managed care) reported having a physician or physician's office as a usual source of care. Medicare beneficiaries have access to the most up-to-date medical technology and procedures.

Under the BBA and other recent legislation, Medicare beneficiaries now have expanded access to many important preventive care services including mammographies, prostate and colorectal cancer screening, bone mass measurements and diabetes self-management services. These benefits will help prevent or reduce the complications of disease for millions of beneficiaries.

Medicare also gives beneficiaries an attractive choice of managed care plans, which can provide coordinated care that is focused on prevention and wellness. As of December 1, 1998, over six million beneficiaries have enrolled in 346 Medicare managed care plans. During the 12-month period ending December 1, 1998, enrollment in the capitated managed care plans called "risk contracts" grew by 16 percent.

In addition, Medicare is working to protect the integrity of its payment systems. Building on the success of Operation Restore Trust, a five-State demonstration aimed at cutting fraud and abuse in home health agencies, nursing homes, and durable medical equipment suppliers, Medicare is increasing its efforts to root out fraud and abuse. Recent legislation provides mandatory Federal funds and greater authority to prevent inappropriate payments to fraudulent providers, and to seek out and prosecute providers who continue to defraud Medicare and other health care programs. Since 1993 the Federal Government has assigned more Federal prosecutors and FBI agents to fight health care fraud. As a result, it has increased prosecutions by over 60 percent, convictions by 240 percent, and saved \$20 billion in health care claims. The budget also proposes legislation that can save Medicare another \$2 billion over the next five years.

Spending and Enrollment

Net Medicare outlays will rise by an estimated 31 percent from 1999 to 2004—from \$201 billion to \$264 billion.¹ Part A outlays will grow by an estimated 30 percent over the period—from \$130 billion to \$169 billion—or an average of 5.4 percent a year. Part B outlays will grow by an estimated 33 percent—from \$71 billion to \$95 billion—or an average of six percent a year.

Medicare is consuming a growing share of the budget. In 1980, Federal spending on Medicare benefits was \$31 billion, comprising 5.2 percent of all Federal outlays. In 1995, Federal spending on Medicare benefits was \$156.6 billion, or just over 10 percent of all Federal outlays. By 2004, assuming no changes in current law, Federal spending on Medicare benefits will total an estimated \$264 billion, or almost 14 percent of all Federal outlays.

Medicare enrollment will grow slowly until 2010, then explode as the baby boom generation begins to reach age 65. From 1995 to 2010, enrollment will grow at an estimated average annual rate of 1.5 percent, from

37.6 million enrollees in 1995 to 46.9 million in 2010. But after 2010, average annual growth will almost double, with enrollment reaching an estimated 61.3 million in 2020.

The Two Trust Funds

HI Trust Fund: As noted earlier in this chapter, the HI Trust Fund is financed by a 2.9 percent payroll tax, split evenly between employers and employees. In 1995, HI expenditures began to exceed the annual income to the Trust Fund and, as a result, Medicare began drawing down the Trust Fund's accounts to help finance Part A spending. Prior to the BBA, the Government's actuaries predicted that the HI Trust Fund would become insolvent in 2001. The BBA, however, extended the solvency of the Trust Fund until 2008.

Medicare Part A still faces a long-term financing challenge. Since current benefits are paid by current workers, Medicare costs associated with the retirement of the baby boomers starting in 2010, will be borne by the relatively small number of people born after the baby boom. As a result, only 2.3 workers will be available to support each beneficiary in 2030—compared to today's four workers per beneficiary. The President plans to work with Congress and the bipartisan Medicare Commission to develop a long-term solution to this financing challenge.

SMI Trust Fund: The SMI Trust Fund receives about 75 percent of its income from general Federal revenues and about 25 percent from beneficiary premiums. Unlike HI, the SMI Trust Fund is really a trust fund in name only; the law lets the SMI Trust Fund tap directly into general revenues to ensure its annual solvency.

Balanced Budget Act Implementation

HCFA continues to implement the many changes in Medicare payment methodologies and provider options that were mandated in the BBA. Although HCFA has been forced to delay some provisions due to the year 2000 (Y2K) computer problem, the agency has issued major rules that implement the new Medicare + Choice program, PSO solvency standards, an interim payment system for home health services and a prospective pay-

¹ These figures cover Federal spending on Medicare benefits, but do not include spending financed by beneficiaries' premium payments or administrative costs.

ment system for skilled nursing facilities. According to the Board of Trustees for the Part A Trust Fund, the reform measures enacted in the BBA extended the solvency of the Part A Trust Fund from 2001 to 2008 and lowered its projected 75-year deficit by about one-half.

Performance Plan

HCFA has developed a set of performance goals to measure its progress in ensuring that Medicare beneficiaries receive the highest quality health care. HCFA's performance goals relate to four critical areas: quality assurance; access to care for the elderly and disabled; administrative efficiency; and a reduction in fraud and abuse. For example, HCFA's 2000 goals include:

- Increasing the percentage of Medicare beneficiaries who receive a mammogram once every two years from 55 percent in 1994 to 60 percent in 2000;
- Increasing the number of Medicare beneficiaries over age 65 receiving vaccinations for influenza from 55 percent in 1995 to 60 percent in 2000;
- Increasing the percentage of Medicare beneficiaries who have at least one managed care choice from 70 percent in 1997 to 80 percent in 2000.
- Decreasing the one-year mortality rate among Medicare beneficiaries hospitalized

for heart attacks from 31.4 percent in 1995 to 27.4 percent in 2000.

- Reducing the telephone busy rate for Medicare carriers, for which measurement will begin in 2000. By 2001, the number of Medicare carriers who answer calls within two minutes and the number who answer 80 percent of calls within one minute will increase.
- Reducing the payment error rate under Medicare's fee-for-service program from 14 percent in 1996 to seven percent in the year 2000 and five percent by the year 2002; and
- Ensuring that all systems necessary for continuity of HCFA payments and other mission critical outputs through and beyond 2000 will be Y2K computer compliant. Specifically, all systems will be certified compliant (mission-critical certified by the independent contractor and others by appropriate HCFA personnel) prior to the need for those systems to process new dates.

The budget includes legislative proposals relating to the Patients' Bill of Rights, long term care, and several proposals expanding Medicare access. Appropriate performance measures will be developed as legislation is enacted and implemented.